UNIVERA IPA, LLC
PARTICIPATING PROVIDER GROUP AGREEMENT

THIS AGREEMENT is entered into as of November 1, 2013, by and between Univera IPA, LLC ("IPA") and ____Erie County Department of Health_____ ("Provider").

WHEREAS, IPA has, as one of its objectives, the arrangement for the delivery of quality health services at a reasonable cost; and

WHEREAS, MCO (as defined below) administers, promotes and arranges for the provision of prepaid medical and related health care services to individuals eligible or enrolled in the health plans described on the attached **Exhibit A** (the "Health Plans") pursuant to a contract or contracts between the MCO and the New York State Department of Health (the "Plan Contracts"); and

WHEREAS, IPA has executed an agreement with the MCO (the "MCO Agreement") pertaining to the Health Plans under the terms of which IPA will arrange for health care providers to deliver certain health care services to Enrollees (as defined below) who are entitled to receive Covered Health Services under the Health Plans; and

WHEREAS, the Provider desires to provide Covered Health Services to the Enrollees of the Health Plans.

NOW THEREFORE, in consideration of the mutual benefits which will accrue to each of the parties to this Agreement, the parties agree as follows:

1. **Definitions**

The following terms will have the definitions indicated:

(a) "Agreement" - This agreement and related attachments, exhibits, and amendments hereto.

(b) "Covered Health Services" - Health care items and services received to which an Enrollee is entitled from MCO under a Plan Contract.

(c) "Emergency" - A medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in; (a) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of behavioral condition placing the health of such person or others in serious jeopardy; (b) serious impairment to such person's bodily functions; (c) serious dysfunction of any bodily organ or part of such person; or (d) serious disfigurement of such person.

[2]Group Member Information: the information requested in **Exhibit F** must be submitted for each Member of the Group

(d) "Enrollee" - An individual who is entitled to receive Covered Health Services under a Health Plan.

(e) "Health Services" - Those Covered Health Services that IPA has determined Provider may provide (through approval of credentials or otherwise) to Enrollees under this Agreement.

(f) "MCO" - The Managed Care Organization identified in **Exhibit A** that contracts with the IPA for the delivery of Covered Health Services under the Health Plans.

(g) "NYSDOH" – The New York State Department of Health.

(h) "Participating Provider" - A physician, allied health professional, community health center, hospital, home care agency, hospice or any other professional, entity or facility which is duly qualified and licensed in the state of New York and who agrees under a direct or indirect agreement with IPA or MCO to provide Covered Health Services to Enrollees.

(i) "Primary Care Physician" - A physician who specializes in general practice, family practice, internal medicine or pediatrics and who agrees to assume primary responsibility for coordinating the overall health care of Enrollees who have been selected or been assigned to the physician as their primary care physician.

(j) "Provider" - The physician, or other health professional, or providers affiliated with physician group who is (are) a party to this Agreement.

2. **Health Services**

(a) Provider represents that he/she is duly qualified and licensed in the state of New York to provide Health Services. Provider further represents that the information contained in Provider's credentialing application with MCO is true, correct and complete in all respects and includes all information necessary so that the information provided is not misleading, and agrees to notify the MCO and IPA immediately of any material change in such information. This shall include, but not be limited to, any suspension or revocation of Provider's professional license, any suspension or loss of any of the Provider's hospital privileges, any exclusions of the Provider from any government health care programs (e.g. Medicaid or Medicare) and the termination or suspension of the Provider's professional liability insurance. Provider acknowledges that any material misstatement in or omissions from any such document will constitute cause for termination of this Agreement by the IPA.

(b) Provider shall comply fully with the IPA's and MCO's provider participation, credentialing and recredentialing, and sanctioning procedures. The Provider grants the MCO and IPA permission to consult with third parties as may be required to verify the information contained in the Provider's credentialing application with the MCO and to obtain any information the MCO may need for recredentialing and to verify any information supplied by the Provider in connection with the recredentialing process.

(c) Provider shall provide all Health Services that are within the scope of the Provider's license. However, Provider recognizes that IPA may, in its sole discretion, limit the Covered Health Services which Provider is permitted to provide to Enrollees irrespective of the scope of Provider's practice and license. Provider recognizes that such limitations may be imposed by IPA for reasons relating to the management of health care, which include, but are not limited to, quality improvement, utilization control, cost control or simply restricting certain Covered Health Services to certain classes of health care providers.

3. **Delivery of Health Services**

(a) Provider shall, during the term of this Agreement and during any applicable post-termination continuation period specified in this Agreement, accept as a patient and provide Health Services to any Enrollee who selects or is referred to Provider irrespective of the Enrollee's health history or current health condition.

(b) Provider shall provide Health Services to the Enrollees of the Health Plans noted on **Exhibit A**. IPA reserves the right, in its sole discretion, to amend **Exhibit A** to include additional Health Plans and/or MCOs. IPA will provide notice to Provider of the terms and conditions relating to the Health Plan and/or MCO added to **Exhibit A** after the date of the Agreement, and Provider shall have 60 days to notify IPA in writing whether Provider wishes to not participate in the Health Plan. In the event that the Provider fails to notify the IPA that he or she wishes to not participate in the Health Plan, Exhibit A shall be deemed amended to include such Health Plan and/or MCO. If Provider decides not to participate in the Health Plan, this Agreement shall remain in effect with respect to the other Health Plans and MCOs listed on **Exhibit A**.

(c) All Health Services shall be rendered by Provider to Enrollees in accordance with the terms and conditions of this Agreement, the Plan Contracts and IPA and MCO provider manuals, guidelines, policies, protocols, and procedures now existing or as hereafter adopted or amended ("IPA Policies"). Provider will comply with the informed consent procedures for Hysterectomy and Sterilization specified in 42CFR, Part 441, sub-part (F), and 18NYCRR Section 505.13 and with applicable EPSDT requirements specified in 42 CFR, Part 441, sub-part (B), 18NYCRR, Part 508, New York State Department of Health C/THP Manual and all applicable public health laws and regulations all of which will be included as part of the IPA Policies.

(d) Provider shall not discriminate against any Enrollee in the delivery of Health Services because of color, race, religion, age, sex, sexual orientation, disability, place of origin, or source of payment. Provider shall comply with the provisions of the Americans with Disabilities Act and all other applicable anti-discrimination laws and regulations in the performance of his or her obligations under this Agreement. Health Services shall be rendered by Provider in the same manner, in accordance with the same standards, and within the same time availability as Provider offers to his/her private-pay or other patients and as necessary to comply with the IPA Policies.

(e) Upon 30 calendar days prior written notice to IPA, Provider may request IPA to transfer Enrollee's care to another Participating Provider if there has been a failure to establish a satisfactory patient relationship. The Provider will continue to provide care to the Enrollee until the transfer is completed.

(f) Upon 30 calendar days prior written notice to IPA, Provider may at any time refuse to accept Enrollees as new patients because Provider's entire case load of all patients does not so permit and Provider is closing his or her practice to all patients, except that Provider will continue to treat those Enrollees who have previously selected or been referred to Provider. When Provider reopens his or her practice to new patients, Provider must promptly notify IPA and begin accepting additional Enrollees as patients.

(g) Each Enrollee shall be required to select a Primary Care Physician responsible for coordinating his or her overall health care. For Enrollees who fail to select a Primary Care Physician one shall be designated from among IPA's network in accordance with written procedures adopted by IPA and the MCO. In the event that the Provider is the Primary Care Physician selected by an Enrollee or designated by IPA for the Enrollee, the Provider shall continue in that capacity until: (1) the Enrollee disenrolls from a Health Plan; provided, however, that if the Enrollee is admitted to a hospital prior to the expected date of disenrollment and is not released from the hospital until after the expected date of disenrollment, the Primary Care Physician shall continue in that capacity until the end of the month in which the Enrollee is discharged from the hospital; (2) the Enrollee selects or is assigned another Primary Care Physician; (3) this Agreement is terminated and any applicable continuation of care period has expired; or (4) the Primary Care Physician self-terminates as Enrollee's Primary Care Physician to the extent permitted by the MCO Policies.

(h) Nothing in this Agreement or the IPA Policies is intended to limit the Provider's open communication with Enrollees regarding appropriate treatment alternatives. This Agreement and the IPA Policies will not cause the Provider to be penalized for discussing with Enrollees or with IPA or the MCO what he or she believes to be care that is appropriate or medically necessary, or for making a report or complaint to a governmental body regarding the delivery of or payment for Covered Health Services or the IPA Policies.

4. **Participating Conditions**

Provider shall do the following:

(a) Assure that Health Services provided by him/her are made available to Enrollees promptly and in a manner that assures continuity of care, which shall include, but not be limited to, coordinating overall health care if Provider is the Enrollee's Primary Care Physician and making referrals when necessary, and exchanging health records and forwarding all information without charge and in a timely manner to all health care providers engaged in the treatment of the Enrollee.

(b) Make certain that Health Services will be provided in a manner which satisfies all applicable requirements of New York State laws and regulations and is consistent with community standards of care and intended to preserve human dignity and patient confidentiality and privacy. Such standards shall include, but not be limited to, acceptable medical and surgical practices, professional and scientific standards prevailing in the service area at the time of treatment, and standards of access and quality promulgated, administered and supervised by the New York State Department of Health or required under the New York Public Health Law.

(c) Participate in the sharing of medical records and other records, whether during the term of this Agreement or subsequent to its termination, without charge and in a manner which is consistent with and/or required by applicable law and IPA Policies, which shall include, but not be limited to, making records available on request of IPA, the MCO or the New York State Department of Health, in order to make determinations regarding, for example, quality, utilization, grievances or review of payment claims.

(d) It is understood that in order to provide Covered Health Services to an Enrollee, Provider may have to refer the Enrollee to other Participating Providers for the purpose of determining what type of Covered Health Service the Enrollee requires and/or for the purpose of providing such required Covered Health Service. All such referrals shall be done in accordance with IPA Policies and will only be made to Participating Providers, except in the case of an Emergency or when no such Participating Provider is reasonably available.

(e) Make necessary and appropriate arrangements with other Participating Providers to assure the availability of Health Services to Enrollees on a 24 hour, seven day a week basis when Provider is not available.

(f) Ensure that all personnel assisting the Provider in rendering covered Health Services are licensed, certified and supervised to the extent required by law.

5. **Compensation**

(a) For all Covered Health Services provided by Provider, Provider shall be reimbursed by MCO or MCO's designee in accordance with the then-current fee schedule applicable to the Health Plan. Provider may access the then-current fee schedule applicable to a Health Plan via MCO's or MCO's designee's secure website. MCO may maintain different fee schedules for different Health Plans. In the event Provider's charge or bill is less than the amount in MCO's fee schedule, MCO or MCO's designee will pay the lesser amount. MCO shall be responsible for paying all claims in accordance with Section 3224-a of the New York Insurance Law and other applicable laws and regulations.

(b) The formula specified in Section 5(a) may be changed by IPA, in its sole discretion, annually or more frequently if IPA so desires, by notifying the Provider in writing thirty (30) days prior to the effective date of such change. However, if the formula change is one that would result in an "adverse reimbursement change", as that term is defined in Public Health Law § 4406-c(5-c), then such formula change will be implemented in accordance with Public Health Law § 4406-c(5-c). If Provider is not satisfied with the fees being paid by MCO in accordance with Section 5(a), above, Provider's only right and remedy is to terminate this Agreement in accordance with paragraph 11 below.

(c) In the event that IPA and Provider agree at a future date to execute a prepaid capitated payment arrangement for Health Services rendered by Provider to Enrollees that is subject to Insurance Department Regulation 164, Provider shall comply with the additional terms set forth in **Exhibit C** to this Agreement.

Should an Enrollee be covered by another health care insurance policy including, but not limited to, third party commercial insurance, no fault automobile insurance or worker's compensation insurance, the Health Plans will generally be the secondary payer. Claims submitted to IPA,

MCO or MCO's designee as the secondary payer should include information regarding the primary payer including carrier, policy number and any applicable explanation of benefits. Provider shall reasonably cooperate with IPA and MCO in all coordination of benefits activities.

6. **Claims Submission**

(a) Provider shall submit proper and complete claims and encounter information to IPA, MCO, or MCO's designee as required by the NYSDOH and the NCQA Standards on the MCO's prescribed forms by forwarding same to IPA, MCO or MCO's designee, as directed by IPA. Such claims and encounter information shall be submitted within one hundred and twenty (120) calendar days following the date on which the Health Service was rendered.

(b) In the event that Provider's claim is not received within the one hundred and twenty (120) day period, then such claim shall be denied and all rights to receive payment from the Enrollee, IPA, MCO or MCO's designee shall be deemed to have been waived by Provider. If a claim has been returned to Provider because of incorrect or incomplete information, or because the claim form has been incorrectly completed and a properly completed claim is not resubmitted within the time specified by IPA, MCO or MCO's designee, then such claim shall be denied and all rights to receive payment from the Enrollee, IPA, MCO or MCO's designee shall be deemed to have been waived by Provider.

(c) An extension of the one hundred and twenty (120) day filing requirement may be granted by IPA, MCO or MCO's designee, in its sole discretion, in the case of the death or disability of Provider, or theft or destruction of records, or such other extenuating circumstances acceptable to IPA, MCO or MCO's designee, provided that an application for extension has been submitted to within a reasonable time after the occurrence of such event.

(d) In the event a claim for payment is properly denied, in whole or in part, or adjusted for any reason (except when the basis for the denial relates to termination of the Enrollee from coverage under the Health Plan), either before or after it is paid, Provider shall not seek payment for such claim from the Enrollee, the IPA, MCO or MCO's designee, as applicable. If a claim is denied or adjusted after it is paid, IPA, MCO, or MCO's designee, as applicable, may, in its sole discretion, obtain repayment from Provider by offsetting the amount owing from payments to Provider for future claims.

(e) Provider shall retain for a period of at least six (6) years from the date of the applicable Enrollee's disenrollment, or in the case of minors' medical records, at least six (6) years after the age of majority all documents relating to and/or supporting any claim submitted, including documents relating to the submission of and payment for such claim, unless the MCO or federal or state law requires retention for a longer period. In the event of an audit, litigation or other action involving such records which arises prior to the expiration of the above referenced periods, such records shall be maintained for a period of six (6) years following the resolution of such audit, litigation or other action if IPA or MCO notifies the Provider in writing that such extension of the usual retention period is required.

(f) IPA shall be responsible for acting on behalf of Provider to handle/address complaints regarding the payment of claims by MCO.

7. **Policies and Peer Review**

(a) Provider shall cooperate in the implementation of procedures and policies of the MCO and of the IPA to the extent applicable laws and regulations permit the IPA to develop policies or implement functions, and the IPA and the MCO may share information collected by them pertaining to Provider, regarding or pertaining to: (1) quality assurance; (2) utilization review; (3) grievances; (4) referrals of enrollees; (5) maintenance of records, record audits and inspection; (6) preventative medicine and other health education for enrollees; and (7) peer review.

(b) Provider shall participate in any and all IPA and MCO Quality Management activities including but not limited to those intended to further the IPA and/or the MCO in achieving accreditation by NCQA as well as accreditation by any other accrediting or regulatory agency. The Provider shall address deficiencies relating to the results of such activities in cooperation with the NYSDOH and any State Quality Assurance Contractors to ensure appropriate compliance and the provision of Covered Health Services to Enrollees. The Provider shall also comply with all quality of care assurances as stipulated in applicable federal and state regulations and statutes.

(c) If Provider violates any provision of this Agreement or any of the IPA Policies, and in the process of which Provider is paid a fee by IPA for Health Services rendered, IPA, MCO or MCO's designee, as applicable, may collect damages from the Provider equal to the fee paid to Provider. IPA, MCO or MCO's designee, as applicable, may, in its sole discretion, collect such damage by offsetting the amount owing from payment for past and future claims. Nothing in this section 7(c) shall preclude the IPA from exercising any other remedy available under this Agreement or applicable law in the event of a violation by the Provider hereunder.

(d) The Provider shall participate and comply with all review requirements required by third parties having jurisdiction over MCO and IPA, including, but not limited to, the review of all Enrollees who have been readmitted to a hospital within thirty (30) calendar days from discharge, have had two (2) or more admissions to a hospital within a consecutive twelve month period, or have been identified by MCO as at high risk for multiple social and/or health care problems.

8. **Insurance**

(a) The Provider, at his/her/its own expense, agrees to maintain professional liability insurance and general liability insurance in the amount of not less than one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) annual aggregate to insure the Provider and the Provider's employees against any claim or claims for damages arising by reason of personal injuries or death occasioned directly or indirectly in connection with the performance of any service provided hereunder, or the use of any property and facilities provided by the Provider in connection with this Agreement. The Provider shall provide IPA with evidence of such coverage upon request and shall agree to keep such coverage current and in effect. In the event that such insurance is provided through self-insurance or by a "captive" insurance company not subject to New York State oversight and/or not covered by the New York State Guaranty Fund, the Provider shall provide to IPA a copy of the annual audited financial statement produced for each such captive insurance company or self-insurance fund within thirty

(30) days after such audited financial statement is completed and an annual certified actuarial report showing that current reserves are adequate for future liabilities. Should the Provider's insurance be written on a claims made basis, the Provider agrees to maintain coverage for claims arising from services rendered during the term of this Agreement, but submitted after the termination of this Agreement. If necessary, Provider will purchase "tail coverage" to meet the financial obligation of this Agreement and instruct its insurer to send IPA a certificate of insurance as evidence of the coverage required by this paragraph.

9. **Records**

(a) Provider shall establish and maintain for each Enrollee to whom Provider provides Health Services, complete and appropriate medical records and administrative and financial records regarding the Health Services provided, which comply with state and federal law, rules and regulations, and with standards of the IPA's and of the MCO's Peer Review and quality assurance program, and which are adequate to ensure continuity of care and to permit assessment of the quality of care, subject to all applicable limitations on the scope of IPA activities in applicable laws and regulations. Such records shall include, but not be limited to, information that accurately reflects the evaluation of the Enrollee and the treatment provided or arranged by the Provider. Provider shall maintain and keep confidential complete and appropriate medical, administrative and financial records regarding all Enrollees to whom the Provider provides Covered Health Services, all financial records that the NYSDOH or other state or federal regulatory bodies with jurisdiction over the IPA or the MCO may require including books, accounts, journals, ledgers, and all financial records relating to capitation payments, third party health insurance recovery and other revenue received and expenses incurred under this Agreement and any accounts, records or other information as may be required to substantiate any estimate, expenditures or reports as required by the NYSDOH or the Office of the State Comptroller as may be necessary for auditing purposes regarding the Health Plans; and appropriate financial records to document fiscal activities and expenditures, including records relating to the sources and application of funds. Provider shall also maintain such other records as the IPA or the MCO may need from time to time to provide information required under the Plan Contracts. Provider shall furnish to MCO, without charge, financial and utilization data as agreed upon by the IPA and MCO to permit MCO to comply with the reporting requirements of the New York State Department of Health, the New York State Insurance Department and the Department of Social Services. Such records shall be maintained in accordance with ethical standards of the medical profession, IPA Policies, applicable law, and this Agreement. Provider shall permit the IPA, the MCO, the New York State Department of Health, the New York State Insurance Department, the Comptroller of the State of New York, the New York State Attorney General, the New York Office of the Medicaid Inspector General, the Department of Health and Human Services, the Comptroller General of the United States and their authorized representatives to have access to all such records and to all other records relating to performance under this Agreement for the purposes of examination, audit and copying, at no charge, of such records to the extent not prohibited by law, regulation or governmental authority. Such access shall be granted on two (2) business days' prior written notice, during normal business hours, unless otherwise provided or permitted by applicable laws, rules or regulations. At a minimum, Provider will retain such records for a period of six (6) years from the date of the applicable Enrollee's disenrollment, or in the case of minors' medical records six (6) years after the age of majority; provided that in the event of an audit, litigation or other action involving such records which arises prior to the expiration of the above-referenced periods, such records shall be

maintained for a period of six (6) years following the resolution of such audit, litigation or other action, if the IPA notifies Provider in writing that such extension of the usual retention is required.

(b) Provider shall also participate in the sharing of medical records and other records, whether during the term of this Agreement or subsequent to its termination, without charge and in a manner which is consistent with and/or required by applicable law, IPA Policies and/ or MCO policies. This shall include, but not be limited to, making records available without charge upon request of the IPA, the MCO or the New York State Department of Health for purposes of inspection and copying. Provider shall be responsible for obtaining any consents or authorizations from Enrollees as required by applicable law for the disclosure of records under this Section.

(c) Information about an Enrollee and medical records shall be released only on written authorization of the Enrollee (or Enrollee's parent or legal guardian when the Enrollee is not of legal age or competent) or when required and/or permitted by law.

(d) Pursuant to authorization by the Enrollee to the extent authorization is required by applicable law, Provider will make Enrollee's medical records and other personally identifiable information including encounter data available to the MCO and IPA with appropriate consent/authorization, for purposes relating to the provision of Covered Health Services to Enrollees, including preauthorization, concurrent review, quality assurance, provider claims processing and payment, subject to applicable patient privacy and confidentiality laws and regulations. The Provider shall provide copies of these records to the IPA and the MCO at no cost.

10. **Term**

Subject to Section 11, this Agreement shall be effective for one (1) year as of the date that IPA signs this Agreement, and if applicable, subject to completion of IPA's credentialing of Provider, and shall automatically renew for successive one (1) year terms on each anniversary of the effective date unless either party provides written notice to the other party of its intention not to renew at least one hundred eighty (180) days prior to the end of the term then in effect.

11. Termination

(a) Termination With Cause:

(i) Upon default in the performance of any material term of this Agreement by either party and failure of the defaulting party to cure such default within fifteen (15) days after written notice from the other party of such default, or, if such default is not susceptible to cure within the fifteen (15) day period, promptly to make provision for such cure and thereafter to pursue such cure diligently to completion within thirty (30) days after written notice from the other party, the non-defaulting party may terminate this Agreement upon sixty (60) days' written notice to the defaulting party and termination will be effective on the expiration of that sixty (60) day period. The Provider will give the MCO notice of any default by IPA, and the MCO shall have the option to cure such default.

(ii) This Agreement may be terminated on thirty (30) days prior written notice and the termination will be effective on the expiration of the thirty (30) days period: (i) by Provider upon suspension, withdrawal, expiration or non-renewal of any federal, state or local license, certificate, approval or authorization which is materially adverse to the operations of IPA or the MCO; (ii) by the IPA and the MCO in the event the Provider refuses to execute any agreement determined by any state or federal regulatory body or agency to be necessary for the regulatory approval and full implementation of any of the Health Plans; or (iii) by one party, upon bankruptcy or insolvency of the other party.

(iii) This Agreement shall terminate immediately and without notice in the event that Provider dies, engages in conduct threatening or causing imminent harm to patient care, upon a determination that Provider has committed fraud, or if Provider is subject to a final disciplinary action by a state licensing board or other governmental agency that impairs the Provider's ability to practice and the termination will be effective immediately.

(iv) This Agreement may be terminated by the IPA immediately upon written notice to Provider in the event of any of the following: (i) the Provider is expelled from any state's Medicaid programs or any of the Health Plans; (ii) upon the cancellation or termination of the Provider's professional liability insurance required by this Agreement without replacement coverage having been obtained; or (iii) in the event of the loss of the Provider's license to provide Covered Health Services.

(v) This Agreement shall terminate automatically in the event of the termination of the MCO Agreement, provided, however, that if one or more of the Health Plans is terminated, this Agreement shall remain in effect for any other Health Plans that are not terminated.

(b) Notice and Hearing: If this Agreement is terminated by the IPA and the MCO for any reason other than pursuant to Section 11(b)(iii), the IPA or MCO will provide to the Provider a written explanation of the reasons for the proposed contract termination and an opportunity for a review or hearing as required by Section 4406-d of the New York Public Health Law and the effective date of the termination shall comply with Section 4406-d(2)(f) of the New York Public Health Law. Written notice of termination under Section 11 shall be deemed given when received by the party to which it is addressed.

(c) Continuation of Care: Pending the effective date of termination, the Provider may not accept, as patients, any new Enrollees or new referrals, and Provider will cooperate with IPA and other Participating Providers in making arrangements for the transfer of Enrollees to new Participating Providers on or before the effective date of the termination. Provider may no longer treat an Enrollee once the termination becomes effective, unless requested to do so by IPA if IPA determines that Provider should complete a plan of treatment commenced by the Provider or, if necessary, because the Enrollee has not been transferred to a new Provider. With IPA approval, the Provider shall continue an ongoing course of treatment with the Enrollee during a transition period of up to 180 days after the date of notice to the Enrollee of the Provider's disaffiliation; or if the Enrollee has entered the second trimester of pregnancy at the time of the Provider's disaffiliation from IPA, for a transition period that includes the provision of post-partum care directly related to the delivery; or if the Enrollee on the effective date of termination is a hospital inpatient or is undergoing an ongoing course of

treatment until discharge, medically appropriate completion of course of treatment or transfer of care to another Provider. Provider agrees to be bound by the terms of the Agreement during this transition period. In the event that this Agreement is terminated as a result of the termination of the MCO Agreement, the Provider shall continue to provide Health Services to Enrollees pursuant to the terms of this Agreement for one hundred eighty (180) days following the effective date of the termination, or until such time as the MCO makes other arrangements, whichever occurs first.

(d) Obligation After Termination: Termination shall not release Provider from his/her obligation to complete treatment, under the terms of this Agreement and subject to the Principles of Medical Ethics of the American Medical Association, when requested to do so by IPA or to cooperate in the referral of Enrollees to other Participating Providers in order to assure continuation of service. Nor shall termination release Provider from his/her obligations under paragraphs 2, 3, 4, 5, 6, 7, 8, 9, 11, 12 and 13 of this Agreement. Termination shall also not affect Provider's right to receive payment for Covered Health Services rendered to Enrollees in accordance with the terms of this Agreement.

(e) No Release: Termination shall not amount to a release of any claim by either party for money owing or for damages, which shall include, but not be limited to, repayment of paid claims if the basis for termination is related to those claims, refund of claims denied or adjusted as referred to in paragraph 6 above, unpaid damages as referred to in paragraph 7 above, and reasonable legal fees incurred by IPA in the process of terminating this Agreement, seeking the collection of damages and enforcing its rights hereunder. Damages owing by Provider to IPA shall be offset against monies owing to Provider for prior unpaid claims.

12. [Intentionally Omitted]

13. **Miscellaneous**

(a) No waiver by either party of a breach or violation of any provision of this Agreement shall be effective unless in writing or shall operate as or be construed to be a waiver of any subsequent breach.

(b) This Agreement shall be governed by and construed in accordance with the laws of the State of New York. The County of Erie in the State of New York is hereby designated as the venue for any action or proceeding arising from or in any way connected to this Agreement.

(c) Every provision of this Agreement is intended to be severable. If any provision is held to be invalid or unenforceable by law or by a court of competent jurisdiction, all other provisions shall nevertheless continue in full force and effect. In lieu of such invalid or unenforceable provision, there shall be added as a part of this Agreement a legal, valid and enforceable provision as similar in terms to such invalid or unenforceable provision as may be possible.

(d) Provider shall not assign or otherwise transfer this Agreement or any interest in this Agreement to any other party, nor may Provider arrange to have another Participating Provider render a Health Service which Provider is responsible for rendering, except as permitted under paragraph 4(e) above.

(e) In the performance of his/her obligations under this Agreement, Provider shall at all times act with respect to IPA as an independent contractor. Neither IPA nor the MCO shall have or exercise any direct control or direction over the methods by which Provider shall perform his/her professional function or Provider-patient relationship.

(f) Provider hereby authorizes IPA and/or the MCO to use his/her name, address, phone number, type of practice and an indication of Provider's willingness to accept additional Enrollees in its roster of Participating Providers and in other promotional materials.

(g) The Provider agrees to comply with all terms and conditions of the MCO Agreement. To the extent this Agreement conflicts with the MCO Agreement, the MCO Agreement shall control. In the event that the MCO Agreement is amended, this Agreement shall automatically and without notice or any further act by either party be deemed amended to conform in all respects thereto. In addition, IPA may make any amendments to this Agreement that are required to comply with any law or regulation by providing notice of such amendment to the Provider. All other amendments or modifications to this Agreement, except as provided otherwise in this Agreement, shall be mutually agreed to in writing by IPA and Provider. Any material amendment to this Agreement shall require the approval of the New York State Department of Health. Such amendments shall be submitted to the New York State Department of Health no less than thirty (30) days in advance of the intended effective date.

(h) By signing this Agreement, Provider expressly authorizes any hospital in New York State to release to IPA all quality assurance and Provider credentialing materials maintained by the hospital, pursuant to New York State Public Health Law Sections 2805-j and

2805-k and Part 405 of the New York State Hospital Code regarding Provider's practice or privileges at that hospital.

(i) Indemnification:

(i) Provider covenants to indemnify and hold the IPA and the MCO harmless from any and all losses, damages or liability, including attorney's fees and costs of enforcement, which may be suffered by the IPA and/or MCO arising out of any breach of this Agreement by Provider or negligence or other unlawful conduct by Provider, or any servant, agent or employee of the Provider upon or in relation to the discharge by Provider of its professional responsibilities to Enrollees. The IPA covenants, in case any claim or demand is asserted against it which may result in liability to Provider hereunder, that the IPA shall give prompt notice thereof in writing to Provider and shall cooperate in the investigation of any such claim or the defense of any such action arising therefrom.

(ii) The IPA covenants to indemnify, and hold Provider harmless from any and all losses, damages or liability, including reasonable attorney's fees and costs of enforcement, which may be suffered by Provider arising out of any breach of this Agreement by the IPA or out of any negligence or other unlawful conduct by the IPA upon or in relation to the discharge of Provider of his/her professional responsibilities to Enrollees. Provider covenants, in case any claim or demand is asserted against him/her/it which may result in liability to the IPA, the Provider shall give prompt notice thereof in writing to the IPA and shall cooperate in the investigation of any such claim or the defense of any such action arising therefrom.

(j) If any dispute shall arise under the terms of this Agreement, and if under the IPA Policies there is a hearing procedure or dispute resolution mechanism which addresses that dispute, Provider must first submit the dispute to the hearing or dispute resolution procedure before commencing legal action against IPA.

(k) In the event any dispute shall arise under the terms of this Agreement, IPA may elect, in its sole discretion, to submit such dispute to arbitration in Rochester, New York, before an arbitrator under the National Health Lawyers Alternative Dispute Resolution Services Rules of Procedure. Such election by IPA may be made at any time prior to the commencement of a judicial proceeding by IPA, or in the event a judicial proceeding is commenced by Provider, at any time prior to the last day to answer and/or respond to a summons and/or complaint made by Provider. The cost of the arbitration shall be borne equally by each party. The parties shall be bound by the decision of the arbitrator, and judgment upon the award may be entered in a court of competent jurisdiction. The Commissioner of the Department of Health will be given notice of all issues going to arbitration, including copies of decisions. The Commissioner of the Department of Health is not bound by arbitration decisions.

(l) Any notice required to be given under the terms of this Agreement shall be delivered personally by each party to the other party's office during normal business hours or sent by certified mail, return receipt requested, postage prepaid. Any notice which is mailed shall be deemed given on the second business day after the day of mailing (not counting the day mailed), irrespective of the date of receipt. Notices may be signed and given by the attorneys for the party giving the notice.

(m) This Agreement constitutes the sole and entire agreement between the parties with respect to the subject matter hereof. This Agreement supersedes any other agreement Provider has previously signed with IPA.

(n) Certification Regarding Lobbying. The IPA and the Provider each certifies on behalf of itself only, and to the best of its knowledge that:

(i) No federal appropriated funds have been paid or will be paid to any person by or on behalf of it for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the award of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment or modification of any Federal contract, grant, loan, or cooperative agreement.

(ii) If any funds other than Federal appropriated funds have been paid or will be paid to any person for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the award of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment or modification of any Federal contract, grant, loan or cooperative agreement, the IPA/MCO or the Provider (as applicable) shall complete and submit Standard Form-LLL "Disclosure Form to Report Lobbying," in accordance with its instructions.

(iii) If the Provider carries out any of the duties of this Agreement through a subcontract, the Provider shall include the provisions of this Section in such subcontract.

(iv) This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction pursuant to 31 U.S.C. Section 1352. The failure to file the required certification shall subject the violator to a civil penalty not less than $11,000 and not more than $110,000 for each such failure.

(o) Anti-Kickback Provisions Provider agrees to comply with the Anti-kickback procedures as set forth in 48 CFR 52.203-7.

(p) Access to Books and Records Provider hereby agrees that, subject to the legality and applicability of Section 952 of the Omnibus Reconciliation Act of 1980 and implementing regulations:

(i) Until the expiration of six (6) years after the furnishing of services under this Agreement, the Provider will make available, upon written request of an appropriate federal officer, this Agreement and any books, documents, and records of the Provider that are necessary to certify the nature and extent of the costs of such services; and

(ii) If the Provider carries out any of the duties of this Agreement through a subcontract with a value or cost of $10,000 or more over a twelve (12) month period

with an organization related to Provider, such subcontract will contain a clause similar to subparagraph (i) above, making available the subcontract, books, documents, and records of such related organization which are necessary to verify the nature and extent of the cost of the subcontracted services, upon written request of an appropriate federal official.

(q) The "New York State Department of Health Standard Clauses for Managed Care Provider/IPA Contracts", attached to this Agreement as **Exhibit B**, are expressly incorporated into this Agreement and are binding upon the parties to this Agreement. In the event of any inconsistent or contrary language between the Standard Clauses and any other part of this Agreement, including but not limited to appendices, amendments and exhibits, the parties agree that the provisions of the Standard Clauses shall prevail, expect to the extent applicable law requires otherwise and/or to the extent a provision of this Agreement exceeds the minimum requirements of the Standard Clauses.

THE REMAINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK

(r) The parties agree to comply with the Managed Care Reform Act and all subsequent revisions to same in the performance of his/her/it obligations under this Agreement.

IN WITNESS WHEREOF, we have signed the Participating Provider Agreement and agree to be bound by all of its terms.

Provider:

Provider Signature [2]: _____

Provider Name (Print): Erie County Department of Health

Provider Address (Print): 95 Franklin Street, Room 906

City, State and Zip Code (Print): Buffalo NY 14202

Provider National Provider Identifier (NPI): 1134210313

Provider Tax Identification Number: 16-6002558

Dated: _____

[2]The physician signing on behalf of the Group represents that he or she has the authority to execute this Agreement on behalf of the Group and to bind the Group and each and every physician practicing in the Group to all terms and conditions of this Agreement.

UNIVERA IPA, LLC

Authorized Signature: _____

Print Name: Dennis Graziano

Title: President and CEO

Dated: _____

County of Erie

By: _____ **Date:** _____
MARK POLONCARZ/RICHARD TOBE
County Executive/Deputy County Executive

APPROVED AS TO CONTENT:

By: Approved Electronically
Gale R. Burstein
Commissioner of Health
Erie County Department of Health

APPROVED AS TO FORM:

By: Approved Electronically
Greg P. Kammer
Assistant District Attorney

UNIVERA IPA, LLC

PARTICIPATING PROVIDER AGREEMENT

Exhibit A

MANAGED CARE ORGANIZATIONS

Univera Community Health, Inc.

HEALTH PLANS:

Medicaid Managed Care ("Plus Med")
Family Health Plus
Child Health Plus

Exhibit B

NYSDOH'S APPENDIX OF STANDARD CLAUSES

Revised 3/1/11

Notwithstanding any other provision of this agreement, contract, or amendment (hereinafter "the Agreement" or "this Agreement") the parties agree to be bound by the following clauses which are hereby made a part of the Agreement. Further, if this Agreement is between a Managed Care Organization and an IPA, or between an IPA and an IPA, such clauses must be included in IPA contracts with providers, and providers must agree to such clauses.

DEFINITIONS FOR PURPOSES OF THIS APPENDIX

"Managed Care Organization" or " MCO" shall mean the person, natural or corporate, or any groups of such persons, certified under Public Health Law Article 44, who enter into an arrangement, agreement or plan or any combination of arrangements or plans which provide or offer, or which do provide or offer, a comprehensive health services plan.

"Independent Practice Association" or "IPA" shall mean an entity formed for the limited purpose of arranging by contract for the delivery or provision of health services by individuals, entities and facilities licensed or certified to practice medicine and other health professions, and, as appropriate, ancillary medical services and equipment, by which arrangements such health care providers and suppliers will provide their services in accordance with and for such compensation as may be established by a contract between such entity and one or more MCOs. "IPA" may also include, for purposes of this Agreement, a pharmacy or laboratory with the legal authority to contract with other pharmacies or laboratories to arrange for or provide services to enrollees of a New York State MCO.

"Provider" shall mean physicians, dentists, nurses, pharmacists and other health care professionals, pharmacies, hospitals and other entities engaged in the delivery of health care services which are licensed, registered and/or certified as required by applicable federal and state law.

B. GENERAL TERMS AND CONDITIONS

1. This Agreement is subject to the approval of the New York State Department of Health and if implemented prior to such approval, the parties agree to incorporate into this Agreement any and all modifications required by the Department of Health for approval or, alternatively, to terminate this Agreement if so directed by the Department of Health, effective sixty (60) days subsequent to notice, subject to Public Health Law §4403(6) (e). This Agreement is the sole agreement between the parties regarding the arrangement established herein.

2. Any material amendment to this Agreement is subject to the prior approval of the Department of Health, and any such amendment shall be submitted for approval at least thirty (30) days, or ninety (90) days if the amendment adds or materially changes a risk sharing arrangement that is subject to Department of Health review, in advance of anticipated execution. To the extent the MCO provides and arranges for the provision of comprehensive health care services to enrollees served by the Medical Assistance Program, the MCO shall notify and/or submit a copy of such material amendment to DOH or New York City, as may be required by the Medicaid managed care contract between the MCO and DOH (or New York City) and/or the Family Health Plus contract between the MCO and DOH.

3. Assignment of an agreement between an MCO and (1) an IPA, (2) institutional network provider, or (3) medical group provider that serves five percent or more of the enrolled population in a county, or the assignment of an agreement between an IPA and (1) an institutional provider or (2) medical group provider that serves five percent or more of the enrolled population in a county, requires the prior approval of the Commissioner of Health.

4. The Provider agrees, or if the Agreement is between the MCO and an IPA or between an IPA and an IPA, the IPA agrees and shall require the IPA's providers to agree, to comply fully and abide by the rules, policies and procedures that the MCO (a) has established or will establish to meet general or specific obligations placed on the MCO by statute, regulation, or DOH or SID guidelines or policies and (b) has provided to the Provider at least thirty (30) days in advance of implementation, including but not limited to:
   - quality improvement/management;
   - utilization management, including but not limited to precertification procedures, referral process or protocols, and reporting of clinical encounter data;
   - member grievances; and
   - provider credentialing.

5. The Provider or, if the Agreement is between the MCO and an IPA, or between an IPA and an IPA, the IPA agrees, and shall require its providers to agree, to not discriminate against an enrollee based on color, race, creed, age, gender, sexual orientation, disability, place of origin, source of payment or type of illness or condition.

6. If the Provider is a primary care practitioner, the Provider agrees to provide for twenty-four (24) hour coverage and back up coverage when the Provider is unavailable. The Provider may use a twenty-four (24) hour back-up call service provided appropriate personnel receive and respond to calls in a manner consistent with the scope of their practice.

7. The MCO or IPA which is a party to this Agreement agrees that nothing within this Agreement is intended to, or shall be deemed to, transfer liability for the MCO's or IPA's own acts or omissions, by indemnification or otherwise, to a provider.

8. Notwithstanding any other provision of this Agreement, the parties shall comply with the provisions of the Managed Care Reform Act of 1996 (Chapter 705 of the Laws of 1996) Chapter 551 of the Laws of 2006, Chapter 451 of the Laws of 2007 and Chapter 237 of the Laws of 2009 with all amendments thereto.

9. To the extent the MCO enrolls individuals covered by the Medical Assistance and/or Family Health Plus programs, this Agreement incorporates the pertinent MCO obligations under the Medicaid managed care contract between the MCO and DOH (or New York City) and/or the Family Health Plus contract between the MCO and DOH as if set forth fully herein, including:

   a. the MCO will monitor the performance of the Provider or IPA under the Agreement, and will terminate the Agreement and/or impose other sanctions, if the Provider's or IPA's performance does not satisfy standards set forth in the Medicaid managed care and/or Family Health Plus contracts;

   b. the Provider or IPA agrees that the work it performs under the Agreement will conform to the terms of the Medicaid managed care contract between the MCO and DOH (or between the MCO and New York City) and/or the Family Health Plus contract between the MCO and DOH, and that it will take corrective action if the MCO identifies deficiencies or areas of needed improvement in the Provider's or IPA's performance; and

   c. The Provider or IPA agrees to be bound by the confidentiality requirements set forth in the Medicaid managed care contract between the MCO and DOH (or between the MCO and New York City) and/or the Family Health Plus contract between the MCO and DOH.

   d. The MCO and the Provider or IPA agree that a woman's enrollment in the MCO's Medicaid managed care or Family Health Plus product is sufficient to provide services to her newborn, unless the newborn is excluded from enrollment in Medicaid managed care or the MCO does not offer a Medicaid managed care product in the mother's county of fiscal responsibility.

   e. The MCO shall not impose obligations and duties on the Provider or IPA that are inconsistent with the Medicaid managed care and/or Family Health Plus contracts, or that impair any rights accorded to DOH, the local Department of Social Services, or the United States Department of Health and Human Services.

   f. The Provider or IPA agrees to provide medical records to the MCO for purposes of determining newborn eligibility for Supplemental Security Income where the mother is a member of the MCO and for quality purposes at no cost to the MCO.

   g. The Provider or IPA agrees , pursuant to 31 U.S.C. § 1352 and CFR Part 93, that no Federally appropriated funds have been paid or will be paid to any person by or on behalf of the Provider/IPA for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the award of any Federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement. The Provider or IPA agrees to complete and submit the "Certification Regarding Lobbying," **Exhibit E**, attached hereto and incorporated herein, if this Agreement exceeds $100,000.

If any funds other than Federally appropriated funds have been paid or will be paid to any person for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of a member of Congress, in connection with the award of any Federal Contract, the making of any Federal grant, the making of any Federal loan, the entering of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement, and the Agreement exceeds $100,000 the Provider or IPA shall complete and submit Standard Form-LLL "Disclosure Form to Report Lobbying,", attached hereto as **Exhibit E**, in accordance with its instructions.

h. The Provider agrees to disclose to MCO on an ongoing basis, any managing employee that has been convicted of a misdemeanor or felony related to the person's involvement in any program under Medicare, Medicaid or a Title XX services program (Block grant programs)

i. The Provider agrees to monitor its employees and staff against the List of Excluded Individuals and Entities (LEIE) and excluded individuals posted by the OMIG on its Website.

j. The Provider agrees to disclose to MCO complete ownership, control, and relationship information.

k. Provider agrees to obtain for MCO ownership information from any subcontractor with whom the provider has had a business transaction totaling more than $25,000, during the 12 month period ending on the date of the request made by SDOH, OMIG or DHHS. The information requested shall be provided to MCO within 35 days of such request.

10. The parties to this Agreement agree to comply with all applicable requirements of the Federal Americans with Disabilities Act.

11. The Provider agrees, or if the Agreement is between the MCO and an IPA or between an IPA and an IPA, the IPA agrees and shall require the IPA's providers to agree, to comply with all applicable requirements of the Health Insurance Portability and Accountability Act; the HIV confidentiality requirements of Article 27-F of the Public Health Law and Mental Hygiene Law § 33.13.

C. PAYMENT / RISK ARRANGEMENTS

1. Enrollee Non-liability. Provider agrees that in no event, including, but not limited to, nonpayment by the MCO or IPA, insolvency of the MCO or IPA, or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a subscriber, an enrollee or person (other than the MCO or IPA) acting on his/her/their behalf, for services provided pursuant to the subscriber contract or Medicaid Managed Care contract or Family Health Plus contract and this Agreement, for the period covered by the paid enrollee premium. In addition, in the case of Medicaid Managed Care, Provider agrees that, during the time an enrollee is enrolled in the MCO, he/she/it will not bill the New York State Department of Health or the City of New York for Covered Services within the Medicaid Managed Care

Benefit Package as set forth in the Agreement between the MCO and the New York State Department of Health. In the case of Family Health Plus, Provider agrees that, during the time an enrollee is enrolled in the MCO, he/she/it will not bill the New York State Department of Health for Covered Services within the Family Health Plus Benefit Package, as set forth in the Agreement between the MCO and the New York State Department of Health. This provision shall not prohibit the provider, unless the MCO is a managed long term care plan designated as a Program of All-Inclusive Care for the Elderly (PACE), from collecting copayments, coinsurance amounts, or permitted deductibles, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to a covered person provided that Provider shall have advised the enrollee in writing that the service is uncovered and of the enrollee's liability therefore prior to providing the service. Where the Provider has not been given a list of services covered by the MCO, and/or Provider is uncertain as to whether a service is covered, the Provider shall make reasonable efforts to contact the MCO and obtain a coverage determination prior to advising an enrollee as to coverage and liability for payment and prior to providing the service. This provision shall survive termination of this Agreement for any reason, and shall supersede any oral or written agreement now existing or hereafter entered into between Provider and enrollee or person acting on his or her behalf.

2. Coordination of Benefits (COB). To the extent otherwise permitted in this Agreement, the Provider may participate in collection of COB on behalf of the MCO, with COB collectibles accruing to the MCO or to the provider. However, with respect to enrollees eligible for medical assistance, or participating in Child Health Plus or Family Health Plus, the Provider shall maintain and make available to the MCO records reflecting COB proceeds collected by the Provider or paid directly to enrollees by third party payers, and amounts thereof, and the MCO shall maintain or have immediate access to records concerning collection of COB proceeds.

3. If the Provider is a health care professional licensed, registered or certified under Title 8 of the Education Law, the MCO or the IPA must provide notice to the Provider at least ninety (90) days prior to the effective date of any adverse reimbursement arrangement as required by Public Health Law § 4406-c(5-c). Adverse reimbursement change shall mean a proposed change that could reasonably be expected to have a material adverse impact on the aggregate level of payment to a health care professional. This provision does not apply if the reimbursement change is required by law, regulation or applicable regulatory authority; is required as a result of changes in fee schedules, reimbursement methodology or payment policies established by the American Medical Association current procedural terminology (CPT) codes, reporting guidelines and conventions; or such change is expressly provided for under the terms of this Agreement by the inclusion or reference to a specific fee or fee schedule, reimbursement methodology or payment policy indexing scheme.

4. The parties agree to comply with and incorporate the requirements of Physician Incentive Plan (PIP) Regulations contained in 42 CFR §438.6(h), 42 CFR § 422.208, and 42 CFR § 422.210 into any contracts between the contracting entity (provider, IPA, hospital, etc.) and other persons/entities for the provision of services under this Agreement. No specific payment will be made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an enrollee.

5. The parties agree that a claim for home health care services following an inpatient hospital stay cannot be denied on the basis of medical necessity or a lack of prior authorization while a utilization review determination is pending if all necessary information was provided before a member's inpatient hospital discharge, consistent with Public Health Law § 4903.

D. RECORDS ACCESS

1. Pursuant to appropriate consent/authorization by the enrollee, the Provider will make the enrollee's medical records and other personally identifiable information (including encounter data for government-sponsored programs) available to the MCO (and IPA if applicable), for purposes including preauthorization, concurrent review, quality assurance, (including Quality Assurance Reporting Requirements ("QARR")), payment processing, and qualification for government programs, including but not limited to newborn eligibility for Supplemental Security Income (SSI) and for MCO/Manager analysis and recovery of overpayments due to fraud and abuse. The Provider will also make enrollee medical records available to the State for management audits, financial audits, program monitoring and evaluation, licensure or certification of facilities or individuals, and as otherwise required by state law. The Provider shall provide copies of such records to DOH at no cost. The Provider (or IPA if applicable) expressly acknowledges that he/she/it shall also provide to the MCO and the State (at no expense to the State), on request, all financial data and reports, and information concerning the appropriateness and quality of services provided, as required by law. These provisions shall survive termination of the contract for any reason.

2. When such records pertain to Medicaid or Family Health Plus reimbursable services the Provider agrees to disclose the nature and extent of services provided and to furnish records to DOH and/or the United States Department of Health and Human Services, the County Department of Social Services, the Comptroller of the State of New York, the Office of the Medicaid Inspector General, the New York State Attorney General, and the Comptroller General of the United States and their authorized representatives upon request. This provision shall survive the termination of this Agreement regardless of the reason.

3. The parties agree that medical records shall be retained for a period of six (6) years after the date of service, and in the case of a minor, for three (3) years after majority or six (6) years after the date of service, whichever is later, or for such longer period as specified elsewhere within this Agreement. This provision shall survive the termination of this Agreement regardless of the reason.

4. The MCO and the Provider agree that the MCO will obtain consent directly from enrollees at the time of enrollment or at the earliest opportunity, or that the Provider will obtain consent from enrollees at the time service is rendered or at the earliest opportunity, for disclosure of medical records to the MCO, to an IPA or to third parties. If the Agreement is between an MCO and an IPA, or between an IPA and an IPA, the IPA agrees to require the providers with which it contracts to agree as provided above. If the Agreement is between an IPA and a provider, the Provider agrees to obtain consent from the enrollee if the enrollee has not previously signed consent for disclosure of medical records.

E. TERMINATION AND TRANSITION

1. Termination or non-renewal of an agreement between an MCO and an IPA, institutional network provider, or medical group Provider that serves five percent or more of the enrolled population in a county, or the termination or non-renewal of an agreement between an IPA and an institutional Provider or medical group Provider that serves five percent or more of the enrolled population in a county, requires notice to the Commissioner of Health. Unless otherwise provided by statute or regulation, the effective date of termination shall not be less than 45 days after receipt of notice by either party, provided, however, that termination, by the MCO may be effected on less than 45 days notice provided the MCO demonstrates to DOH's satisfaction prior to termination that circumstances exist which threaten imminent harm to enrollees or which result in Provider being legally unable to deliver the covered services and, therefore, justify or require immediate termination.

2. If this Agreement is between the MCO and a health care professional, the MCO shall provide to such health care professional a written explanation of the reasons for the proposed contract termination, other than non-renewal, and an opportunity for a review as required by state law. The MCO shall provide the health care professional 60 days notice of its decision to not renew this Agreement.

3. If this Agreement is between an MCO and an IPA, and the Agreement does not provide for automatic assignment of the IPA's Provider contracts to the MCO upon termination of the MCO/IPA contract, in the event either party gives notice of termination of the Agreement, the parties agree, and the IPA's providers agree, that the IPA providers shall continue to provide care to the MCO's enrollees pursuant to the terms of this Agreement for 180 days following the effective date of termination, or until such time as the MCO makes other arrangements, whichever first occurs. This provision shall survive termination of this Agreement regardless of the reason for the termination.

4. Continuation of Treatment. The Provider agrees that in the event of MCO or IPA insolvency or termination of this contract for any reason, the Provider shall continue, until medically appropriate discharge or transfer, or completion of a course of treatment, whichever occurs first, to provide services pursuant to the subscriber contract, Medicaid Managed Care contract, or Family Health Plus contract, to an enrollee confined in an inpatient facility, provided the confinement or course of treatment was commenced during the paid premium period. **For purposes of this clause, the term "provider" shall include the IPA and the IPA's contracted providers if this Agreement is between the MCO and an IPA**. This provision shall survive termination of this Agreement.

5. Notwithstanding any other provision herein, to the extent that the Provider is providing health care services to enrollees under the Medicaid Program and/or Family Health Plus, the MCO or IPA retains the option to immediately terminate the Agreement when the Provider has been terminated or suspended from the Medicaid Program.

6. In the event of termination of this Agreement, the Provider agrees, and, where applicable, the IPA agrees to require all participating providers of its network to assist in the orderly transfer of enrollees to another provider.

F. ARBITRATION

1. To the extent that arbitration or alternative dispute resolution is authorized elsewhere in this Agreement, the parties to this Agreement acknowledge that the Commissioner of Health is not bound by arbitration or mediation decisions. Arbitration or mediation shall occur within New York State, and the Commissioner of Health will be given notice of all issues going to arbitration or mediation, and copies of all decisions.

G. IPA-SPECIFIC PROVISIONS

1. Any reference to IPA quality assurance (QA) activities within this Agreement is limited to the IPA's analysis of utilization patterns and quality of care on its own behalf and as a service to its contract providers.

Exhibit C

NEW YORK STATE DEPARTMENT OF INSURANCE REGULATION 164 PROVISIONS

(1) Provider will not, in the event of default by the IPA, demand payment from the MCO for any covered services rendered to Members for which the in-network capitation payment was made by the MCO to the IPA pursuant to a MCO Agreement that includes a prepaid capitation arrangement and is subject to the New York State Department of Insurance's Regulation 164.

(2) Provider shall not collect or attempt to collect from Member any amounts owed to Provider for covered services, other than any amounts a Member is obligated to pay under the applicable Subscriber Agreement.

(3) In the event a MCO Agreement is terminated by the New York State Department of Insurance's Superintendent ("Superintendent") pursuant to 11 N.Y.C.R.R. § 101.9(a)(7) of the New York Insurance Department regulations, this Agreement must be assigned on a prospective basis (without any obligation to pay any amounts owed to the Participating Dentist by the IPA) to each MCO that entered into a MCO Agreement with IPA for a period of time that is determined by either (i) the Commissioner of the New York State Department of Health with respect to MCOs certified pursuant to Article 44 of the Public Health Law, or (ii) the Superintendent with respect to all other MCOs. This assignment is necessary in order to provide the services that the MCO is legally obligated to deliver to its Members. However, no such assignment shall exceed twelve (12) months from the date the MCO Agreement is terminated by the Superintendent.

Exhibit D

Payment Agreement

Date:_____

Dear Doctor _____:

You have explained to me that the health services described below are not covered under my HMO Insurance coverage because either:

(a) The health service is not a covered benefit under my HMO contract.

Nevertheless, I have directed you to render the health services requested. I understand that the cost of such services will not be paid, in whole or in part, by HMO, and you will not submit a claim to HMO. I hereby agree to pay you in full for the cost of the health services described below.

Your disclosure to me as described above and my signing of this Agreement were done prior to your providing the health services to me.

_____ _____

Provider Patient

Health Services:

_____

_____

_____

NOTE: Provider is required to provide a copy of this acknowledgment to HMO and the patient.

EXHIBIT E
CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge, that:

1. No Federal appropriated funds have been paid or will be paid to any person by or on behalf of the Provider for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of a Member of Congress in connection with the award of this Federal loan, the entering into any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

2. If any funds other than Federal appropriated funds have been paid or will be paid to any person for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress in connection with the award of any Federal contract, the making of this Federal grant, the making of any Federal loan, the entering into any cooperative agreement, or the extension, continuation, renewal, amendment or modification of this Federal contract, grant, loan, or cooperative agreement, and the Agreement exceeds $100,000, the Provider shall complete and submit Standard Form-LLL "Disclosure Form to Reporting Lobby," in accordance with its instructions.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction pursuant to U.S.C. Section 1352. The failure to file the required certification shall subject the violator to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

DATE: _____

TITLE: _____

ORGANIZATION: _____

NAME: (Please Print) _____

SIGNATURE: _____

Disclosure of Lobbying Activities
Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure)

1. Type of Federal Action	**2. Status of Federal Action:**	**3. Report Type:**
a. contract b. grant c. cooperative agreement d. loan e. loan guarantee f. loan insurance Select one: _____	a. bid/offer/application b. initial award c. post-award Select one: _____	a. initial filing b. material change Select one: _____ **For material change only:** Year _____ Quarter _____ Date of last report _____

4. Name and Address of Reporting Entity:	**5. If Reporting Entity in No. 4 is Subawardee,**
Prime _____ Subawardee _____ Tier _____ *,if known:* Congressional District, *if known:* _____	Address _____ City _____ State _____ Zip code _____ Congressional District, *if known:* _____
6. Federal Department/Agency:	**7. Federal Program Name/Description:**
_____	_____ CFDA Number, *if applicable*: _____
8. Federal Action Number, *if known*:	**9. Award Amount, *if known*:**
_____	**$** _____
10. a. Name and Address of Lobbying Registrant	**10. b. Individuals Performing Services** *(including address if different from No. 10a)*
(if individual, last name, first name, MI) Address _____ City _____ State _____ Zip code _____	*(last name, first name, MI)* Address _____ City _____ State _____ Zip code _____

11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Signature _____
Print/Type Name _____
Title _____
Telephone No.: _____ Date:

Federal Use Only	**Authorized for Local Reproduction** **Standard Form - LLL (Rev. 7-97)**

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime Federal recipient, at the initiation or receipt of a covered Federal action, or a material change to a previous filing, pursuant to title 31 U.S.C. section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action. Complete all items apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.

2. Identify the status of the covered Federal action.

3. Identify the appropriate classification of this report. If this is a followup report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.

4. Enter the full name, address, city, State and zip code of the reporting entity. Include Congressional District if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g. the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grants.

5. If the organization filing the report in item 4 checks "Subawardee," then enter the full name, address, city, State and zip code of the prime Federal recipient. Include Congressional District, if known.

6. Enter the name of federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.

7. Enter the Federal program name or description for the covered Federal action (item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.

8. Enter the most appropriate Federal identifying number available for the Federal action identified in item 1 (e.g. Request for Proposal (RFP) number, Invitations for Bid (IFB) number; grant announcement number; the contract, grant, or loan award number; the application/proposal control number assigned by the Federal agency). Included prefixes, e.g. "RFP-DE-90-001".

9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in item 4 or 5.

10. (a) Enter the full name, address, city, State and zip code of the lobbying registrant under the Lobbying Disclosure Act of 1995 engaged by the reporting entity identified in item 4 to influence the covered Federal action.
    (b) Enter the full names of the individual(s) performing services, and include full address if different from 10(a). Enter Last Name, First Name and Middle Initial (MI).

11. The certifying official shall sign and date the form, print his/her name, title and telephone number.

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univera Community Health

Please mail or fax to:
Univera Community Health
Provider Contracting
1120 Pittsford-Victor Road
Pittsford, NY 14534
Fax: (585)586-6415

Current Practitioner List by Tax ID

Business Name	Erie County Department of Health	**Tax ID**	16-6002558
		Group NPI	1134210313
Office Manager	Mary Jo Carle	**Phone**	(716) 858-2737
Service Address	608 William Street Buffalo, NY 14206	**Phone**	(716) 858-7687
		Fax	
		Email	N/A
County	Erie		
Billing Address (if different from service address)	95 Franklin St. Room 906 Buffalo, NY 14202	**Phone**	(716) 858-7663
Billing Manager	Madalyn Ladenslager	**Phone**	(716) 858-7663
Office Hours	Monday through Friday 8:30 AM - 4:30 pm	**After Hours**	N/A

Last Name	First Name	NPI	SSN	Date of Birth	Specialty	Credentialed with Univera?
See Exhibit F						

**Attached additional roster sheet if necessary.

NAME OF PROVIDER: Erie County Department of Health (ECDOH)

UNIVERA IPA, LLC

EXHIBIT F

Individual Group Member Information

Effective:

For each individual physician member of the Group, please provide the following information (this page may be photocopied if additional space is needed):

Provider First Name	Provider Last Name	DOB	NPI #	SS #	Specialty
Gale	Burstein, MD	01/26/64	1447282199	125384303	Pediatrics, Preventive Med - Public Health
Heather	Territo, MD	01/16/81	1215183421	088664952	Pediatrics, Emergency Med
John	Crane, MD	07/11/55	1013966720	461088402	Internal Medicine – Infectious Disease
Ryosuke	Osawa, MD	01/27/77	1104035997	112925952	Internal Medicine – Infectious Disease
Jane	O'Leary, NP	03/11/45	1649577735	104363776	Women's Health
Sheila	Summers, NP	01/30/40	1972546422	058320956	Obstetrics/Gynecology
James	Hurd, PA	03/23/75	1760452411	099703311	N/A
Steven	Krolczyk, PA	10/07/72	1700841723	120669530	N/A
Amy	Rutecki, PA	09/19/82	1972731875	091724527	N/A
Young	Tato, PA	10/05/56	1689853061	568893592	N/A
Gina	Weaver, PA	04/03/84	1912186503	064700377	N/A

F

STATE OF NEW YORK

LEGISLATURE OF ERIE COUNTY
CLERK'S OFFICE

BUFFALO, N.Y., September 23, 1999

TO WHOM IT MAY CONCERN:

I HEREBY CERTIFY, *That at the 17th Session of the Legislature of Erie County, held in the County Hall, in the City of Buffalo, on the* ***Twenty-third*** *day of* ***September*** *A.D., 1999, a Resolution was adopted, of which the following is a true copy:*

WHEREAS, the Erie County Department of Health provides primary and specialty care at various locations throughout Eric County.

NOW, THEREFORE, BE IT

RESOLVED, that the Erie County Legislature authorizes the County Executive to enter into agreements through the Erie County Health Department with various managed care organizations, commercial insurance providers and Child Health Plus plans for the purpose of reimbursement for services provided, and be it further

RESOLVED, that certified copies of this resolution be forwarded to the Department of Health, the Division of Budget, Management and Finance, Office of the Comptroller and the Department of Law.

Reference: Comm. 16E-52

9/28/99 To: Trometer Gerstman

RECEIVED
SEP 27 1999
ECHD ADMINISTRATION

ATTEST

Laurie A. Manzella

LAURIE A. MANZELLA
Clerk of the Legislature of Erie County